

A Framework for Conducting a Root Cause Analysis in Response to a Sentinel Event

Level of Analysis	Possibilities	Questions	Findings	Risk Reduction Strategies	Measurement Strategies
What happened?	Sentinel event	What are the details of the event?			
		What area/service was impacted?			
Why did it happen?	Human error	What was the error?			
What was the proximate cause(s)? <small>(Typically a "special cause" variation)</small>	Process deficiency	What was the missing or weak step?			
	Equipment breakdown	What broke?			
Controllable environmental factors		What factors directly affected the outcome?			
Uncontrollable external factors		Are they truly beyond the organization's control?			
Other		Are there any other factors that have directly influenced this outcome?			
Why did that happen? What processes were involved? <small>(May involve "special cause" variation, "common cause" variation, or both)</small>	Patient care process(es) <small>(Specify)</small>	What are the steps in the process? Flow chart	Cause-effect; Change analysis; Failure mode & effect analysis	Fault tree analysis <small>(eg, simplification, redundancy)</small>	<small>(eg, "fail-safe" design, redundancy)</small>
			What steps were involved in (contributed to) the event?		
			What is currently done to prevent failure at this step?		
			What is currently done to protect against a bad outcome if there is a failure at this step?		
			What other areas or services are impacted?	Failure mode & effect analysis	<small>(Generalize improvements to all applicable areas)</small>

